FEANTSA

31 March 2009

FEANTSA Contribution

Consultation on EU action to reduce health inequalities

FEANTSA, the European Federation of National Organisations Working with the Homeless is an umbrella of not-for-profit organisations which participate in or contribute to the fight against homelessness in Europe. It is the only major European network that focuses on homelessness at the European level.

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Introduction

FEANTSA[1], the European Federation of National Organisations working with the Homeless, was established in 1989 as a European non-governmental organisation. The more than 100 member organisations of FEANTSA come from about 30 European countries, including 25 EU Member States. Members are non-governmental organisations that provide a wide range of services to homeless people including accommodation, social and health related support. Most of the members of FEANTSA are national or regional umbrella organisations of service providers. They work in close co-operation with public authorities, social housing providers and other relevant actors. FEANTSA is the only major European network that focuses on homelessness and housing exclusion at European level. It receives financial support from the European Commission for the implementation of its activities. It works closely with the EU institutions, and has consultative status at the Council of Europe and at the United Nations.

FEANTSA and its members are committed to the promotion and respect of fundamental rights and support a rights-based approach in tackling homelessness (in its broadest meaning[2]). FEANTSA's thematic work focuses on data collection, employment, health, housing, housing rights and participation. Its main activities are: trans-national exchanges, research, advocacy and policy work at European and national level.

FEANTSA's Health and social protection working group has been active for several years and has worked on a number of issues related to health and homelessness[3]. In 2006, in the context of FEANTSA's annual theme on health and homelessness, national reports and a European report were published, while a European conference was devoted to the same topic. In this context, issues such as the health profile of people who are homeless, health care entitlements, barriers hindering access to health services, access to quality services, training of professionals, networking and inter-agency work, data collection and the right to health were discussed[4].

Since 2007, FEANTSA coordinates the European Network of Homeless Health workers (ENHW), which is a multi-disciplinary initiative taking the form of a virtual network aimed at persons working with homeless people in a health capacity across Europe[5].

Consultation

FEANTSA welcomes the increasing awareness and political will at EU level to tackle health inequalities[6], which prevent part of the population from accessing their fundamental rights, enjoying better life conditions and meaningfully participating in society. It also welcomes the opportunity to contribute to the present consultation.

Evidence concerning the correlation between socio-economic and health status has been provided by a number of studies and sources, including those mentioned in the Roadmap and the consultation document[7]. Social exclusion and homelessness have an unquestionable impact on people's state of health and well being[8]. Research shows that among people who are homeless there are higher

[1] For more information on FEANTSA's structure and activities, please visit www.feantsa.org.

[2] FEANTSA believes that homelessness does not limit itself to rough sleeping. Homelessness and housing exclusion are complex and multifaceted realities. It has developed a European Typology of Homelessness and housing exclusion as a means of improving understanding and measurement of homelessness, which classifies homeless people according to their living situation: rooflessness (without a shelter of any kind, sleeping rough); houselessness (with a place to sleep but temporary in institutions or shelter); living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence); living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding). See ETHOS.

[3] See FEANTSA web page devoted to health and social protection: http://www.feantsa.org/code/en/theme.asp?ID=2.

[4] See FEANTSA Annual European Report 2006 "The Right to Health is a Human Right: Ensuring Access to Health for People who are Homeless". See web page devoted to the 2006 annual theme: http://feantsa.horus.be/code/EN/theme.asp?ID=35.

[5] See ENHW web page: http://feantsa.horus.be/code/EN/pg.asp?Page=759

[6] When referring to "health inequalities" we understand "health inequities", meaning health differences that are unfair and unjust. See M Whitehead, G Dahlgren, "Levelling up (part 1): a discussion paper on concepts and principles for tackling social inequities in health", WHO, 2006.

[7] Including the WHO Commission on social determinants of health Final Report "Closing the Gap in a Generation: health equity through action on the social determinants of health", 2008.

[8] A very comprehensive definition of health is set out in the preamble to the WHO Constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

morbidity rates and a significantly lower life expectancy compared to the general population. Severe poverty, hardship and precarious housing situations have a direct impact on health, while homelessness can also be a result of existing health related problems.

Based on its expertise and areas of activities, FEANTSA contribution will focus on the relevant questions of the consultation as appropriate. In addition, we will raise issues, which have not necessarily been mentioned and that we feel should be taken into account in any further reflection concerning the way vulnerable groups, such as people who are homeless, are affected by health inequalities, how these can be effectively bridged and what the EU's role in this context can be.

QUESTIONS FOR CONSULTATION

On general data

What do you think will be the trends regarding health inequalities? Are they increasing or decreasing for example – please supply evidence if possible.

- between Member States (e.g. major differences in terms of health outcomes)
- between socio-economic groups.

According to recent estimates, income inequality and poverty are rising in most OECD countries[9]. Knowing that there are large differences in health status depending on economic status, level of education, place of residence, gender and ethnic group belonging, these findings suggest that health inequalities will continue increasing.

In this context, it should be noted that due to the precarious and difficult living situation they are faced with, homeless and severely excluded people are already in a position where they have no choice but to prioritise their needs. As a result, they are not likely to put health in the first place, unless it becomes an acute condition. This is very problematic for a variety of reasons.

What kind of indicators do you think would be necessary to better monitor the extent of Health Inequalities in the EU?

Given the complexity of the issue and the number of influencing factors, there is a need to have an exhaustive understanding of elements having an impact on the health situation of people, and of vulnerable groups in particular, in a range of areas. Causal linkages and inter-linkages should be understood and addressed in a comprehensive way, if health inequalities are to be dealt with effectively.

Indicators should relate to the overall socio-economic, cultural and environmental conditions of people. These should take into account individual risk factors, social factors, living and working conditions related factors (including housing conditions, employment status, level of income, etc.) and broader environmental factors[10].

The legal and policy framework should also be taken into consideration, as they have a direct impact on the ability of people to address their health needs (the way the health system is organised, the way the right to health[11] is implemented, health care entitlements, etc.).

As for the most vulnerable and in particular the homeless population, there is a need for specific indicators, which fully take into account their situation. For instance, the use of the "self perceived health indicator", although very common in data collection on the health situation of a given population, does not appear to be the most appropriate for homeless people, as usually it does not reflect their real health situation.

[9] See OECD's report "Growing Unequal", 2008. Web site: http://www.oecd.org/document/53/0,3343,en_2649_33933_41460917_1_1_1_1,00.html.

[10] See for instance the Social Protection Committee set of common indicators for the social protection and social inclusion process: http://ec.europa.eu/employment_social/spsi/common_indicators_en.htm.

[11] There are a number of international instruments containing provisions on the right to health, to which EU Member States are bound to, such as the UN International Covenant on economic, social and cultural rights, the Council of Europe (revised) European Social Charter, the Charter of Fundamental Rights of the European Union.

Measuring the life expectancy of people who are severely excluded or homeless compared to the life expectancy of the general population across Europe would provide for a reliable indicator on how poor their overall health situation is. This would also show how urgently needed are targeted measures to tackle homelessness and severe exclusion, including in terms of health policies.

If you think monitoring and reporting needs improvement in this area, what kind of monitoring tools should be used?

Homeless and severely excluded people are usually invisible to traditional national statistic instruments and mechanisms. If they are to be reached, and if the data collected are to be of use, it is important to develop targeted surveys and involve relevant stakeholders[12].

Despite the lack of a systematic data collection, it can be said that a variety of studies and academic research relating to health and homelessness are already available at different levels[13]. Medical research and publications focusing on specific health conditions of homeless people are quite well developed, while there are less comprehensive studies combining different aspects and disciplines. The available information should be used as a basis for further knowledge building and monitoring.

One effective way of collecting data and monitoring the health needs of homeless people is to involve relevant homeless service providers. Doctors' surgery and clinics specifically targeting homeless people often collect some data on the health situation of users. There are a number of initiatives across Europe aiming at better assessing the health situation of homeless people, existing hurdles in terms of access to services and gaps relating to the lack of adequate policy responses. Good practice includes joint initiatives involving both academics and field actors[14].

Considering the link between health and other factors, in addition to data on the prevalence of illnesses among homeless and severely excluded people (physical, mental health and addiction related data), it would be useful to collect simple data relating to aspects such as housing situation (independent, supported housing, homeless), administrative status (ID card, on the population register, health insurance, entitlements), income (income, benefits), education, social network and employment situation[15]. The systematic collection of such data would give a clear indication on which area need to be taken into account when designing policies and targeted measures.

On scope of level of EU action/subsidiarity

Do you think action at EU level could make a difference in addressing health inequalities? Why?

There are a number of EU policies, which have an impact on health, health systems and health determinants. FEANTSA agrees that health inequalities cannot be influenced by health policies alone: there is a need for coordinated and integrated action, which should involve a range of policy areas, including social, economic and environmental policies[16].

Action to bridge health inequalities is at the cross roads of different policy areas and levels of competence. In order to be effective, measures to reduce health inequalities will have to be integrated in policy areas such as public health, social policies, housing, employment, economic policy, internal market and competition, immigration, asylum, cohesion policy, environment, transport, research, education and training, etc. Policies relating to food distribution to the most deprived or quality of social and health services of general interest are also relevant in this context. Of course, this needs to be done in a way that respects subsidiarity, but the EU can make a difference in areas where it has direct competence and through other tools, some of which already existing.

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[12] See FEANTSA work on data collection: http://feantsa.horus.be/code/EN/theme.asp?ID=4 and FEANTSA's European Observatory on Homelessness web page: http://www.feantsaresearch.org/code/en/hp.asp.

[13] See FEANTSA web section devoted to health: http://www.feantsa.org/code/en/theme.asp?ID=2.

[14] See for instance initiative currently being prepared by the Spanish members of FEANTSA.

[15] See Laere IRAL van, "De sociaal geneeskundige heeft niets te zeggen", Tijdschr Gezondheidswet 2007; 85(7):367-9. Mentioning this kind of basic information on the death certificate of homeless people could also contribute to giving a valuable indication on life expectancy related to socio-economic status. Recent research suggests that homelessness is an independent risk factor for mortality. See: Morrison DS, "Homelessness as an independent risk factor for mortality: results from a retrospective cohort study"; Int. J. Epidemiology, 2009 (ahead of print).

[16] See "Health in all policies", EC web site: http://ec.europa.eu/health/ph_overview/other_policies/health_other_policies_en.htm.

Considering the impact of EU legislation in a number of areas affecting health and health inequalities, the systematic impact assessment of future legislation and policies from a fundamental rights, social and health-related point of view is crucial.

There are a number of mechanisms in place, which the EU can use to support better knowledge and progress at different levels. The EU can play a crucial role in facilitating exchanges and sharing of information, including through the Open Method of Coordination (OMC) mechanism, which can be an effective tool for strategic mutual learning[17].

It can also fund relevant research, projects and actors, which will bring relevant elements for tackling health inequalities[18]. FEANTSA believes that the EU could also facilitate and drive forward the work on data collection in relation to health inequalities and access to quality care for excluded and vulnerable groups, which would help Member States to progress in this area.

Other opportunities to gather relevant data and raise awareness on the inter-linkages between severe exclusion and homelessness and health status are the focus year on homeless and housing exclusion 2009 and the European Year 2010 for combating poverty and social exclusion.

How should relevant stakeholders be supported and engaged at EU level in tackling health inequalities?

Relevant stakeholders, including civil society organisations, play an important role across a range of social and health areas and therefore in the fight against health inequalities too. The EU has an important role in helping them realise their potential, where this is not already the case. Also, it can support, both politically and financially, relevant initiatives. Organisations like FEANTSA have a widespread membership across Europe and are in contact with a range of actors at national and field level working on a daily basis with vulnerable groups. Through the ENHW for instance, it reaches more than 350 health professionals across Europe who work with homeless people. In general, successful pilot experiences should be supported and used as an example for further initiatives.

Should there be a common commitment at EU level to reduce health inequalities for example by committing to common milestones and reduction targets? If yes, what do you think these milestones or targets should be (what variables? what extent?)?

If, as mentioned in the EU Health Strategy, action to reduce health inequalities aims at ensuring that the health needs of the most disadvantaged are fully addressed, FEANTSA agrees that the first step needed is a strong political commitment, which needs to be followed by coordinated and meaningful action, including proper resources, at the different levels of competence and across the different relevant policy areas.

What would be the right tools to ensure that common goals are achieved on national and EU level (reporting, benchmarking, OMC, etc)?

Existing mechanisms should be used as a basis for further developments, including relevant information gathered through the OMC process.

To what degree can health inequalities be addressed through health policy? How?

Vulnerable groups of the population should be a specific target for preventative health policies and measures. In general, due to a number of barriers in access to care, poor and severely excluded people are likely not to go to the doctor until the condition they are suffering from becomes serious. This is worsened by the fact that usually healthy food and adequate housing are not affordable.

[17] See Joint Report on Social Protection and Social Inclusion 2008, which contains a section on health inequalities; peer review on access to care and health status inequalities in a context of health care reform (2007): http://www.peer-review-social-inclusion.eu/peer-reviews/2007/Access-to-care-and-health-status-inequalities-in-a-context-of-healthcare-reform.

[18] See for instance DETERMINE: http://www.health-inequalities.eu/ and "Quality in and equality of access to healthcare services", 2008: http://www.ehma.org/files/HealthQuest_en.pdf .

Severe social exclusion is clearly a vulnerability factor in terms of health status and it is important to make sure that this is duly taken into account when assessing the health needs of people[19]. Also, this would be a way of helping diminishing negative attitudes and stigmatisation.

The training of health professionals appears to be a relevant aspect in this context. It would be important that both future and experienced health professionals are better aware of health inequalities, the way they affect peoples' life and well being, and the way they can be tackled on a daily basis. Curricula and specific training courses for general practitioners (GPs), nurses, but also social workers and people working in the general education system should include this topic, as there is a need for cross sectoral and multidisciplinary cooperation on health inequalities. A number of interesting pilot initiatives have been developed in this area and would gain in being shared[20].

Which and to what extent should other policy areas, such as social policy, contribute to reducing health inequalities?

Together with health policy, social policy appears as being a crucial area where much can be done to address health inequalities. Together with Member States, the EU has an important role to play to combat social exclusion, improve public health and ensure that everyone's basic needs are met. The fight against poverty and social exclusion appears to be crucial for tackling health inequalities[21].

What is important is to encourage cross sectoral cooperation and integrated policies in this context. As mentioned above, it should also be borne in mind there are other policy areas, which need to be involved outside the health and social policy domain.

Possible Actions and impacts

Given the current economic situation can you think of any immediate action that EU or Member States could take to avoid an increase of health inequalities in the short term?

In general, it can be said that the decrease in people's purchase power, the increase in the unemployment rate, raising housing costs and other (in)direct consequences of the current crisis are likely to have an impact on peoples' health and on health inequalities.

If it is important to respond quickly and in an appropriate way to the crisis, it should be borne in mind that some elements influencing the ability of vulnerable group to access health care services are more structurally linked to policy options and choices in the different areas.

In this context, if we want policies to have a positive and sustainable impact, it is crucial to assess their implications on the most vulnerable and the way they can mutually reinforce each other in addressing health inequalities in the long term. Emergency measures cannot and should not replace necessary and sustained funding to the health care and social systems.

Do you believe that investments through structural funds could help to reduce health inequalities? If so how and why?

Structural funds may encourage Member States to take action and invest in this area. This should be seen as a positive element in the fight against health inequalities and should be open to all Member States.

Where do you think should future investments through structural funds be mainly spent to be effective for reducing health inequalities and what would be the expected impact of that spending?

Small scale innovative projects should be supported, tested and then mainstreamed.

[19] See for instance The Ontario Physicians Poverty Work Group, "Strategies for physicians to mitigate the health effect of poverty", Ontario Medical Review, 2008.

[20] See for instance innovative course: Certificate in Provision of Healthcare to People Experiencing Homelessness at the University of Oxford, which aims at health professionals, support workers, volunteers and all people who deal with homelessness in any aspect of their work: http://www.conted.ox.ac.uk/courses/details.php?id=77.

[21] See K Judge, S Platt, C Costongs, K Jurczak, "Health inequalities: a Challenge for Europe", Study commissioned by the UK Presidency of the EU, 2006.

What in your opinion are other areas that EU and Member States should be encouraged to focus on to achieve a reduction of health inequalities?

FEANTSA agrees that ideally, as mentioned in the WHO report, every government policy and programme should be assessed for its impact on health and health equity.

To what extent would existing coordination and monitoring processes at EU level need to be improved to strengthen joint action on health inequalities?

Tackling health inequalities can literally change the life of very vulnerable groups of the population. In terms of priorities, it is important that existing coordination and monitoring processes first focus on target groups where there is scope for progress and where measures are likely to have a direct impact, including people who are homeless.

What could be possible actions in other EU policy areas on health inequalities and what could be there impact?

What shall be done by the EU in order to facilitate the exchange of experiences between Member States, regions and cities?

How should EU policies be stream-lined in order to reach targeted beneficiaries in the best way? (Disadvantaged, women, migrants, children)

In order to be effective, policies aimed at the most vulnerable need a targeted approach, a clear action plan and adequate resources. Considering the number of barriers and difficulties in accessing treatment, severely excluded people, including homeless people, should be targeted by specific programmes and focused efforts, if they are to be reached.

Also, policies to reduce health inequalities are likely to be more successful when there is a clear action plan focused on specific targets. Given the extreme form of poverty and exclusion they are faced with, there is no doubt that homeless and severely excluded populations should be part of the targets.

In general, the more focused and integrated the strategy for action, the greater the probability that health outcomes will change in the desired direction[22]. Given the cross cutting nature of the issue, it would be important to foresee a mechanism for co-ordinating and monitoring the implementation of policy.

To what extent do you think is the improvement of research capacities advantageous for fighting HI? Can you name any concrete examples?

Targeted research is of vital importance to understand the different aspects involved in tackling health inequalities. Examples, where we believe more in depth knowledge might be of interest in this context are:

- A systematic and broad ranging study on the causal relationship between health and extreme poverty and homelessness would be of interest.

- The link between health and adequate housing conditions is evident, although not always used for policy design purposes. Evidence relating for instance to eviction practices, homelessness and poor health conditions and how this can be prevented, could be of interest.

- There are examples of recent changes or reforms in health care systems where the access to health care for homeless people has suffered. If undertaken without consideration for vulnerable groups already living on reduced means, the evolution of health care systems and cuts in the health care budget may have a tremendous impact on their state of health and ability to afford treatment. It would be interesting to assess health systems reforms in the light of changes in terms of access to health for vulnerable users. The work to improve quality and financial sustainability of health should not be at the expense of equity of access.

[22] See European Observatory on Health Systems and Policies web site: http://www.euro.who.int/observatory.

- A wide study on health care entitlements of specific vulnerable groups would be of use. One aspect of health care which falls usually outside such entitlements is dental care and this has a direct impact on very poor people's health. Also, it would be important to have an overview of what are the health care entitlements of both undocumented migrants and of EU-10 citizens who moved to EU-15 countries and find themselves destitute after loosing their job.
- Another area, which could be researched in cooperation with the EU Agency for fundamental rights, is related to the way access to fundamental rights are implemented and to which extent the reality differs from rights and entitlements on paper. This can be due for instance to discrimination or conflicting policy measures (for instance immigration, asylum, security policies and international commitments on human rights).
- Both health and housing are areas where there is a need to better understand the link between policy making (direct or indirect) and access to and protection of fundamental rights. This is especially true as access to both housing and health can be considered as a precondition for the exercise of other fundamental rights.
- Another area of interest would be to compare, from a cost-effectiveness perspective, the costs deriving from specific vulnerable groups' late recourse or inappropriate use of emergency services vs. the financial implications related to a preventative and integrated health policy aiming at the same specific target groups (which would be complemented by support measures).

Other points

Do you know of any examples of good practice in addressing health inequalities which would be helpful to share with the Commission or other stakeholders – if yes please supply details.

Please provide any other contributions which you wish to add.

Homelessness and health inequalities

FEANTSA wishes to highlight some relevant issues related to homelessness and health inequalities[23]. While there are no illnesses specific to homelessness, the health situation of homeless people worsens in relation to their overall situation. Health issues can be the among the trigger factors leading to homelessness, while they are also one of its consequences. Homeless people are faced with very difficult and unhealthy living conditions, as well as with difficulties in accessing quality health care due to a number of factors.

When addressing health inequalities, this needs to be taken into account, as well as their very vulnerable situation. In this context, FEANTSA would like to insist on the fact that the relationship between people who are faced with severe exclusion and homelessness and (health) service providers cannot be compared to a simple supplier-consumer relationship[24].

Also, it should be borne in mind that for a range of reasons, people who are poorest tend to have the greatest healthcare needs, but also the worst access to care. This is known as the "Inverse care rule" and it means that "the availability of good medical care tends to vary inversely with the need for it in the population served"[25]. Health is a human right and FEANTSA believes that order to grant equity in

[23] See FEANTSA European report 2006 ibid.; contribution to the Peer review devoted to Access to care and health status inequalities in a context of healthcare reform, which was held in Hungary in 2007: http://ec.europa.eu/employment_social/spsi/peer_review_en.htm.

[24] See FEANTSA contribution to the European debate on social services of general interest "SSGI should cater for the needs of the most vulnerable": http://www.feantsa.org/files/Services%20of%20general%20interest/SSGI_FEANTSA_2June2007.pdf .

[25] Christina Masseria, LSE Health: "Access to Care and Health Status Inequalities in a Context of Healthcare reform", 2007, see: http://www.peer-review-social-inclusion.net/peer-reviews/2007.

access to healthcare, the framework within which the provision of healthcare operates needs to take into account the needs of the most vulnerable[26].

Health profile of people who are homeless

People who are homeless often suffer from chronic and severe health problems, including issues related to physical health, mental health, substance abuse and dual diagnose (suffering simultaneously from mental illness and drug addiction). Rates of certain serious infectious diseases are significantly higher among the homeless population than the general population, including HIV, tuberculosis and hepatitis. There are also high levels of drug and alcohol abuse and far higher rates of mental ill-health among people experiencing homelessness than among the general population.

Access to health care

Access to health care for people who are homeless is problematic for a number of reasons, including:

- Administrative and financial barriers, including burdensome administrative procedures and out of pocket payment for consultations, which prevent homeless people to afford health care and medicines. Also, some treatments appear to be less accessible to homeless people, such as dental health care or detoxification treatment.

- Health care entitlements: among EU Member States, there is a variety of healthcare and social protection systems, which include provisions for vulnerable groups not able to pay for health care. If there are generally clear entitlements to access health care for free or at minimum cost when the homeless person is a country national or when in a regular administrative situation. However, if this is true in theory, it does not always correspond to the reality, as people who are homeless are usually still faced with a number of hurdles to overcome (lack of awareness of entitlements, need to provide necessary evidence for accessing rights, local connection, etc.). Undocumented migrants are in a problematic situation as minimal provisions usually lead to a lack or insufficient access to subsidised health care, which is becoming increasingly restrictive throughout the EU[27]. Fear may discourage them from seeking medical help when necessary and have a public health impact. In recent years, homeless service providers have also witnessed and increasing demand from users from EU-10 countries moving to EU-15 countries, who find themselves without work and destitute and have difficulty in accessing services due to lack of entitlements.

- Gap between homeless and hospital life: shame and stigma, previous negative experiences, inflexible appointment procedures, necessity of managing competing needs, reluctance to recognise need for care constitute barriers to health care.

- Multiple and complex needs usually constitute a challenge to the medical model, which is not adapted to work holistically across a range of specialist areas. Co-morbidity occurs frequently among the homeless population, who may be requested first to solve the other condition before being granted access to treatment. This often results in care. There is therefore a need for partnerships between different health care and social providers, which will support the coordination of treatment processes, as well as for appropriate resources and funding for programmes providing integrated treatment of alcohol misuse, somatic and psychiatric conditions.

- Emergency care: when access to care is problematic, people tend to go to the doctor only when the condition becomes acute. Although a safety net for the most vulnerable, this is not

[26] See FEANTSA Reaction to the Consultation Regarding Community Action on Health Services: http://www.feantsa.org/files/Health%20and%20Social%20Protection/Policy%20Statements/FEANTSA%20Reaction%20to%20the%20Consultation%20Regarding%20Community%20Action%20on%20Health%20Services.doc.

[27] See FEANTSA 2006 European Report and PICUM, "Access to Health Care for Undocumented Migrants in Europe", 2007 http://www.picum.org/?pid=210.

the most appropriate setting for care and prevention or early treatment are usually more effective.

- Adequate environment for treatment: to recover, it is assumed that the patient will eat well, maintain hygiene standards, rest, which extremely difficult for homeless people. In general, not having a home is a major cause of vulnerability. Where treatment requires regular medication, it is hard for homeless people to adhere to a strict treatment plan due to their very situation. There are few facilities to allow homeless people to recuperate in a supported environment.

- Discharge practices: in some countries the number of people who are being discharged to no fixed abode is increasing[28]. Hospitals may be tempted to reach cost efficiency through early discharge, which undermines the outcome of the medical intervention. Discharge from institutions, such as prisons, care institutions, psychiatric institutions, etc. is very problematic too, especially if the follow-up in terms of health has not been foreseen. In this context, there is a need for follow-up in terms of formal or informal counselling following discharge.

The way forward

Homelessness and housing exclusion are complex and multifaceted. As homelessness affects different dimensions and spheres of people's life, it is important to adopt an integrated approach which takes into account both health and social aspects.

In this context, to address health needs of people who are homeless, there is a need for inter-agency work and cross sectoral cooperation, as well as for specific and targeted measures, such as outreach services composed of multidisciplinary teams, low-threshold services as well as appropriate resources and funding for programmes providing integrated treatment. This requires commitment and leadership, as does the fight against health inequalities.

FEANTSA is willing to contribute to any further reflection and action in this context.

For more details, visit FEANTSA web site www.feantsa.org or contact Stefania.delzotto@feantsa.org.

FEANTSA is supported financially by the European Commission. The views expressed herein are those of the authors and the Commission is not responsible for any use that may be made of the information contained herein.

[28] See Report by Grant Shapps MP, Shadow Housing Minister, "Discharged with no fixed abode", September 2008.